



State of Louisiana
Louisiana Department of Health
Office of Public Health

CONFIDENTIAL REPORTING WORKSHEET

Pt. Name: _____		MRN: _____		SS#: _____ - _____ - _____																															
Address: _____				Tel: () _____ - _____																															
City: _____		Parish: _____		State: _____ Zip: _____																															
Sex (at birth): <input type="checkbox"/> Male <input type="checkbox"/> Female		Date of Birth: ____/____/____		Country of Birth: <input type="checkbox"/> USA <input type="checkbox"/> Other: _____																															
Gender (as applicable): <input type="checkbox"/> Male to female transgender <input type="checkbox"/> Female to male transgender		Race (check all that apply): <input type="checkbox"/> American Indian/Alaskan <input type="checkbox"/> Native Hawaiian <input type="checkbox"/> White <input type="checkbox"/> Black/African American <input type="checkbox"/> Asian <input type="checkbox"/> Unknown		Hispanic Ethnicity: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Unknown																															
Diagnostic Tests		Collection Date (mm/dd/yyyy)		Ordering Site (if other than reporting facility)																															
Preliminary (report positives): <input type="checkbox"/> IA 1 <input type="checkbox"/> IA 1/2 Check if rapid <input type="checkbox"/> <input type="checkbox"/> Ag/Ab Combo (4 th Gen, lab-based) <input type="checkbox"/> Determine (rapid) Ag+____ Ab+____		____/____/____																																	
Supplemental/Differentiating (report all): <input type="checkbox"/> Western Blot Pos____ Neg____ <input type="checkbox"/> Multispot 1+____ 2+____ Neg____ <input type="checkbox"/> Geenius 1+____ 2+____ Neg____		____/____/____		<input type="checkbox"/> Check if result Indeterminate																															
<input type="checkbox"/> Viral detection - Qual DNA or RNA PCR (NAT): Pos/Det____ Neg____		____/____/____																																	
<input type="checkbox"/> Other (specify): _____		____/____/____																																	
If labs not available, date reporting facility documented pt's diagnosis:		____/____/____																																	
Clinical Status Tests																																			
<input type="checkbox"/> Viral load – Quant RNA PCR (NAT) Copies/ml: _____		____/____/____																																	
<input type="checkbox"/> CD4 T-lymphocytes: Count____ Percent:____		____/____/____																																	
Opportunistic Infections (OIs) – see list on reverse. Please document type and date of diagnosis in Comments section.																																			
Most recent negative test: <input type="checkbox"/> per lab report <input type="checkbox"/> per patient		____/____/____		Test type (if known): _____																															
Insurance provider: _____																																			
<table border="1" style="width:100%; border-collapse: collapse;"> <tr> <th align="left" colspan="3">Patient History / Risk Factors (please complete all lines)</th> </tr> <tr> <td style="width:5%; text-align: center;">Yes</td> <td style="width:5%; text-align: center;">No</td> <td style="width:90%;"></td> </tr> <tr> <td align="center"><input type="checkbox"/></td> <td align="center"><input type="checkbox"/></td> <td><input type="checkbox"/> Sex with male</td> </tr> <tr> <td align="center"><input type="checkbox"/></td> <td align="center"><input type="checkbox"/></td> <td><input type="checkbox"/> Sex with female</td> </tr> <tr> <td align="center"><input type="checkbox"/></td> <td align="center"><input type="checkbox"/></td> <td><input type="checkbox"/> Injected nonprescription drugs</td> </tr> <tr> <td align="center"><input type="checkbox"/></td> <td align="center"><input type="checkbox"/></td> <td><input type="checkbox"/> Heterosexual relations with (check all that apply): <input type="checkbox"/> Injecting Drug User <input type="checkbox"/> Bisexual Male (for female pts) <input type="checkbox"/> Person with hemophilia/coagulation disorder <input type="checkbox"/> Transfusion/transplant recipient <input type="checkbox"/> Person with known HIV infection</td> </tr> <tr> <td align="center"><input type="checkbox"/></td> <td align="center"><input type="checkbox"/></td> <td><input type="checkbox"/> Rec'd clotting factor for hemophilia/coag. disorder</td> </tr> <tr> <td align="center"><input type="checkbox"/></td> <td align="center"><input type="checkbox"/></td> <td><input type="checkbox"/> Rec'd transfusion of other blood/blood components Dates (mo/yr): Earliest____ Latest____</td> </tr> <tr> <td align="center"><input type="checkbox"/></td> <td align="center"><input type="checkbox"/></td> <td><input type="checkbox"/> Rec'd tissue/organ transplant or artificial insemination</td> </tr> <tr> <td align="center"><input type="checkbox"/></td> <td align="center"><input type="checkbox"/></td> <td><input type="checkbox"/> Blood/body fluid exposure in a healthcare or clinical lab setting (mo/yr): ____/____ (Include details on reverse)</td> </tr> </table>						Patient History / Risk Factors (please complete all lines)			Yes	No		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Sex with male	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Sex with female	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Injected nonprescription drugs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Heterosexual relations with (check all that apply): <input type="checkbox"/> Injecting Drug User <input type="checkbox"/> Bisexual Male (for female pts) <input type="checkbox"/> Person with hemophilia/coagulation disorder <input type="checkbox"/> Transfusion/transplant recipient <input type="checkbox"/> Person with known HIV infection	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Rec'd clotting factor for hemophilia/coag. disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Rec'd transfusion of other blood/blood components Dates (mo/yr): Earliest____ Latest____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Rec'd tissue/organ transplant or artificial insemination	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Blood/body fluid exposure in a healthcare or clinical lab setting (mo/yr): ____/____ (Include details on reverse)
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For Females: Is patient currently pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk If yes, estimated date of delivery: ____/____/____ Has the patient delivered a live-born infant? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk If yes, date of most recent delivery: ____/____/____ Delivery hospital (most recent live-born infant): _____ City/State: _____																																			
Patient Notification: Has the patient been notified of his/her HIV test results? <input type="checkbox"/> YES <input type="checkbox"/> NO Partner Services: (see reverse for info) <input type="checkbox"/> I give Office of Public Health staff permission to conduct partner services for this patient. <input type="checkbox"/> I will conduct partner notification for this patient. <input type="checkbox"/> I have discussed partner notification with this patient and s/he will notify partners.																																			
Reporting Facility: _____		Date: _____		Please send or fax to:																															
Address: _____		City: _____		Monica Pendelton																															
Reporting Physician: _____		State: _____		LDH Office of Public Health / SHP																															
Person Completing Form: _____		Zip: _____		1450 Poydras St, Ste 2136																															
		Phone: _____		New Orleans, LA 70112																															
		Phone: _____		P:(504)599-0496 Fax:(504)568-8384																															

To Our Providers:

This worksheet was developed to assist with timely reporting of HIV cases by the diagnosing and/or managing physician, by collecting the most critical information requested on the Centers for Disease Control and Prevention (CDC)'s Adult Case Report Form. In some cases, staff of the STD/HIV Program (SHP), under the Dept of Health and Hospitals Office of Public Health, may need to contact the provider for additional information not included on this worksheet. If a provider prefers to complete the CDC Adult Case Report Form him- or herself, copies may be obtained from the SHP contact listed at the bottom of the form. Case reports may also be made by phone to the SHP contact, or SHP staff can complete the required forms on site via a chart review. *Please include as much information as is available; partial or approximate dates are acceptable for historical information.*

Reporting Requirements: Louisiana's Public Health Sanitary Code (Title 51, Part II, Chapter 1) requires that any physician practicing medicine in the State of Louisiana who attends, examines, or prescribes to a person with HIV infection must report the case by the end of the work week after the existence of a case, suspected case, or a positive laboratory result is known (Class C). HIV infection in pregnancy and perinatal HIV exposure are reportable within one business day (Class B). Other health care providers, laboratories, and other entities have similar reporting requirements.

HIPAA Guidelines Related to Disclosures for Public Health Activities: The Privacy Rule permits covered entities to disclose protected health information, without authorization, to public health authorities who are legally authorized to receive such reports for the purpose of preventing or controlling disease, injury, or disability. See 45 CFR 164.512(b)(1)(i).

Risk Factors and Cases of Public Health Importance: Information on patient risk factors and likely mode of HIV transmission is used in planning prevention activities and to more effectively allocate HIV-related resources. The CDC also closely monitors for any new cases of **HIV-2**; for HIV transmission through a rare or unusual route such as transfusion, transplant, or occupational exposure; and for any cases in children age 12 and under not due to perinatal HIV exposure. Such cases, collectively known as "Cases of Public Health Importance (COPHI)", often require a special investigation and should be reported to your regional contact as soon as suspected.

Partner Services: OPH Disease Intervention Specialists (DIS) make a good faith effort to locate any individual identified as a spouse, sexual contact, or needle-sharing partner of a person newly diagnosed with HIV infection (source patient), to notify the partner(s) of the possible exposure, provide counseling about the risk of infection, and offer testing for HIV infection and other STDs. In performing these activities, the DIS first attempt to contact the source patient's medical provider to determine how partner notification will be conducted. If neither the source patient nor the medical provider is able to adequately conduct this notification, the DIS will seek to interview the source patient directly to identify partners for counseling, testing, and referral. *Notification of partners is conducted in such a manner as to maintain the confidentiality of the source patient.* Partner Services is a valuable prevention activity, as well as a means to offer follow-up services and support to newly diagnosed patients and promote their linkage to care.

(Continued from Clinical Status section on front)

Opportunistic Infections (OIs): *If patient has a current or previous diagnosis of any of the following, please note the condition and date of diagnosis in Comments.*

- Candidiasis, bronchi, trachea, or lungs
- Candidiasis, esophageal
- Carcinoma, invasive cervical
- Coccidioidomycosis, disseminated or extrapulmonary
- Cryptococcosis, extrapulmonary
- Cryptosporidiosis, chronic intestinal (>1 mo. duration)
- Cytomegalovirus disease (other than in liver, spleen, or lymph nodes)
- Cytomegalovirus retinitis (with loss of vision)
- HIV encephalopathy
- Herpes simplex: chronic ulcer(s) (>1 mo. duration); or bronchitis, pneumonitis, or esophagitis
- Histoplasmosis, disseminated or extrapulmonary
- Isosporiasis, chronic intestinal (>1 mo. duration)
- Kaposi's sarcoma
- Lymphoma, Burkitt's (or equivalent term)
- Lymphoma, immunoblastic (or equivalent term)
- Lymphoma, primary in brain
- *Mycobacterium avium* complex or *M. kansasii*, disseminated or extrapulmonary
- *M. tuberculosis*, pulmonary
- *M. tuberculosis*, disseminated or extrapulmonary
- *Mycobacterium*, of other species or unidentified species, disseminated or extrapulmonary
- *Pneumocystis jirovecii* pneumonia (formerly *P. carinii*)
- Pneumonia, recurrent, within a 12-month period
- Progressive multifocal leukoencephalopathy
- Salmonella septicemia, recurrent
- Toxoplasmosis of brain
- Wasting syndrome due to HIV

Comments (Opportunistic infections, additional risk information, antiretroviral meds, partner information, etc.):
